STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

RHODE ISLAND DEPARTMENT OF HEALTH :
BOARD OF MEDICAL LICENSURE AND :
DISCIPLINE :
:
IN THE MATTER OF :
BRYAN JOSEPH GUILFOYLE, M.D. :
LICENSE NO. MD 8830 :

ADMINISTRATIVE DECISION

This matter came on for hearing on diverse dates before a designated Hearing Committee of the Board of Medical Licensure and Discipline (hereinafter "Board").[1] The hearings were conducted pursuant to an Amended Statement of Charges brought by the State against Dr. Guilfoyle (hereinafter "Guilfoyle" or "Respondent"). The Amended Specification of Charges contains twelve counts of what the State alleges to be unprofessional conduct on the part of the Respondent. Both parties were present throughout the proceedings and represented by legal counsel.

TRAVEL AND FACTS

The Respondent began his Rhode Island practice in internal medicine as a staff physician at Kent County Memorial Hospital in 1995. Shortly after his arrival there, he encountered trouble with the hospital administration. There were complaints from hospital staff with respect to issues with the Respondent's patient care and his demeanor in the hospital. These complaints were referred to the Confidential Peer Review

[1] The Hearing Committee consists of three Board members who are designated by the Director of Health. The Hearing Committee that was originally designated and conducted the first hearing in this matter was disbanded when it was determined that two of the members had participated in the investigatory phase of

Committee at the hospital. The Committee commenced an investigation in October, 1995, only four (4) months after Respondent's arrival at the hospital. As a result of its investigation, the Committee determined to conduct an intensive review of Respondent's care and treatment of his patients for a period of thirty (30) days. During that period no adverse issues were identified, but the Committee requested a further monitoring period of two (2) months. Following that two (2) month period, the Committee took no action against Respondent, and he continued on staff at the hospital. In fact, the record (State's 5) is replete with complaints received by the Committee regarding Respondent's treatment of patients and rudeness toward staff during the calendar years 1995 and 1996. However, no action against his privileges was taken. He was referred to the Physician's Health Committee. They recommended that the case against Respondent be closed without further action.

At about the time that the above was occurring, the Respondent was involved in a marital dispute. His familial problems escalated to the point where he was arrested for assault. That incident was reported to the Executive Committee of the hospital, which, apparently, took no action on it.

Likewise, in 1997, there were numerous complaints about Respondent's hostile interactions with patients and staff, as well as several complaints related to patient care. No action was taken by the Committee other than to delay Respondent's elevation within the hospital from "Associate" Staff Physician to "Active" Staff Physician. (State's 5)

In February, 1998, the Respondent was cited by the hospital for ordering a "STAT" peg insert for a patient on a weekend. The procedure required the hospital to

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this case. The two members were replaced and the parties agreed that their replacements could rely on the transcript of the first hearing without the necessity of retaking that testimony.

open the operating room and bring in a surgical team. The Respondent was alleged to have been insistent and rude to staff with respect to his decision that the peg insertion was a "STAT" order. The surgery was performed on the weekend, and, apparently, the patient had a favorable outcome. The rub with the hospital seemed to be Respondent's insistence that the procedure be performed on the weekend which was against hospital policy. The complaint regarding that incident is what finally brought Respondent's activities within the hospital to the forefront with the Executive Committee. In April, 1998 the Committee voted to suspend Respondent's privileges at the hospital and refer him to the Impaired Physicians Program. The Respondent requested, and was granted, a hearing on his suspension. After hearing, the Respondent was offered reduced privileges at the hospital provided he obtained his Board Certification in internal medicine and that he comply with certain other requirements. The Respondent did not comply with the Committee's directives, and he, therefore was never readmitted to staff at the hospital.

Throughout this same period, in addition to treating patients at Kent, Respondent was maintaining a private medical office wherein he saw patients. Commensurate with the onset of his marital problems and the suspension of his hospital staff privileges, the situation began to deteriorate in Respondent's private office, too. Several office staff members testified at the hearing. They stated that the Respondent was nasty to patients and to them. They also testified that on an almost daily basis, the Respondent would go out to lunch and return to the office drunk. One staff member testified that on these occasions, the Respondent would often take the wrong patient's chart into the examining room, and that he made prescription errors. She stated that she sometimes received telephone calls from local pharmacies questioning whether the right drugs had been

ordered for a patient. If she were not there to hand him the charts, the Respondent would sometimes mix them up. The witness also stated that Respondent kept marijuana in a drawer in the office and in his medical bag. Though she never physically saw him smoking marijuana, the witness testified that the Respondent would sometimes "disappear" into the back room of the office, and she could smell the marijuana burning.

The witness further testified that at times when Blue Cross personnel was scheduled to come into the office to review the Respondent's files, that he would supplement the files in advance of the Blue Cross visit and direct her to transcribe them in her own hand so they would match the original file entries. That is, the Respondent would add information that he had not, but should have obtained at the time of the patient visit.

A second staff member of the medical office corroborated the testimony of the first. She testified that after his loss of hospital privileges and the onset of his divorce, things spiraled out of control in the office. Respondent was drinking and treating patients while under the influence of alcohol and/or drugs. She also observed marijuana being stored in Respondent's desk drawer. She testified that the Respondent was often verbally abusive with patients, sometimes throwing them out of the office and using expletives. The witness confirmed the fact that charts were not kept current and that when Blue Cross representatives were scheduled to come to the office to conduct chart reviews, the Respondent would make up information to be added to the charts and have his assistant transcribe it in her penmanship so it would appear to be in sequence. The added information would include blood pressure readings, temperatures, pulse rates and other statistical data that the Respondent fabricated in advance of the Blue Cross visit.

In the late summer and early fall of 1999, the Respondent was being monitored for substance abuse by the Physicians Health Committee. On one particular day during that time period, the witness arrived at the Respondent's office early in the morning for work. The Respondent was already in the office. He was dressed in the same clothes that he had been wearing the previous day. He was sweating and shaking. He had foam around his mouth. He told the witness that he had been vomiting. He prepared a syringe and screamed at her to inject him with it. She did so, and the Respondent went into his office where he was passed out for several hours. The witness cancelled all of his patient appointments for that day. (The Respondent later testified that the liquid in the syringe was compazine).

On another day, Respondent came into the office carrying a jar of clear liquid. He told the witness that it would "cleanse" him in the event he was called by the Physicians Health Committee and directed to submit to a urine screening.

Joseph DiPetro, the Vice President of Operations and General Counsel for Kent County Hospital, also testified. He stated that in 1999 it was brought to his attention that the Respondent might want to harm Dr. Baute, the CEO of the hospital. Specifically, Mr. DiPetro's secretary told him that her child's babysitter had encountered the Respondent at a restaurant. The babysitter told the hospital employee that the Respondent had told her that he wanted to kill Dr. Baute. The police were contacted and conducted an investigation. No criminal charges were ever brought against the Respondent with respect to Dr. Baute, but Dr. Baute did file for, and obtain, a Restraining Order against the Respondent.[2]

[2] Throughout the proceedings, there is testimony relative to an alleged conspiracy on the part of the Respondent and another individual to employ the services of a "hit" man to "whack" Dr. Baute and plant

The State presented testimony relative to the Respondent's treatment of several patients. With respect to one married couple, both of who were patients, there is ample evidence to support the fact that the Respondent was prescribing vast amount of narcotics and opiates without any patient visit, record or diagnosis supporting the prescriptions or evidencing a need for them. (See State's 21,22,25,26,27 and 29) The records produced by the State establish that the Respondent was providing multiple prescriptions for numerous quantities of scheduled drugs to these patients on at least a weekly basis. The patients would fill them at different pharmacies (sometimes on the same day) apparently in order to avoid suspicion. It is unclear what the patients were actually doing with the drugs, i.e. using them, selling them or otherwise.

The Respondent testified that he issued the prescriptions to the patients as a means of providing "pain management". He stated that these patients frequently stopped by the office unannounced. He would see them on those occasions and fail to enter any information in their patient records. He testified that he was allowing the patients to "self-medicate", to choose the dose and type of medication that they wanted to take on a particular day from among the array of drugs that he prescribed for them. He stated that

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drugs on the Respondent's wife. The other individual is an attorney who has been disbarred from the practice and is currently incarcerated at a federal prison. The attorney apparently wore a wire when making these "hit" plans with Respondent. The wire was to have been used as evidence by the FBI in a case against the Respondent. The Respondent, in his own testimony, admitted to these conversations, but testified that he never had any intention of following through with them. In fact, he testified that the attorney had arranged for Respondent to meet the "hit" man on a particular might when Respondent was out with the attorney. The two of them began driving to a location where they were to meet the supposed killer. The Respondent did not believe the attorney to be serious. When it became apparent to the Respondent that the attorney was serious, the Respondent turned the car around and refused to proceed with the plans of the attorney. The State has attempted to introduce a deposition of the attorney wherein he has testified to the events. The Respondent has objected stating that the conversations were privileged and/or motivated by the attorney's desire to incorporate the Respondent in a plan hatched solely by the attorney so that the attorney could then implicate the Respondent in a crime and thereby ingratiate himself with the FBI to obtain a reduced prison sentence. Given the Respondent's own testimony and the failure of any charges being brought against Respondent, the Board deems it unnecessary to consider the attorney's deposition in this matter.

he never saw evidence of drug addiction or adverse drug reaction in these patients. One of these patients was a DEA enforcement officer who had been terminated from his DEA employment. The Respondent was further aware that the patient had previously engaged in altering prescriptions given to him by another doctor and that the patient was a potential drug abuser. The Respondent gave the patient the prescriptions anyway, sometimes vicodin, dilaudid and/or percocet on the same day.

With respect to another patient, (see State's 3) the Respondent prescribed drugs for her without an adequate patient history, assessment or diagnosis. The Respondent's notes in the patient chart detail other medications the patient was taking pursuant to her treatment with other doctors. The Respondent's records do not address any physical symptoms of the patient that would support the prescriptions being given, nor is there any indication that the Respondent consulted with the patient's other treatment providers. At one point in the hearing, the Respondent suggested that his records were more extensive than those being offered into evidence by the State. There was a clear suggestion, totally unsubstantiated, that the State had been given additional records that they were withholding from the Hearing Committee. State's 31 establishes that the Respondent, among other things, prescribed a codeine derivative for the patient despite being informed that the patient was allergic to codeine. Not long after the Respondent began treating this patient, she died. After her death, the Respondent testified that he learned that the patient was an alcoholic and a drug abuser.

The State also produced testimony from the son of one of Respondent's elderly patients. The patient had a problem with her knee for which the Respondent had referred her for an MRI. When the patient and son saw the Respondent after the MRI, the patient

was still complaining of pain. The Respondent stated that the problem was with the patient's sciatica, and began writing her a prescription. The son challenged the diagnosis, suggesting that the MRI revealed a torn miniscus and stating that the mother would be seeing another doctor. The son testified that the Respondent then became verbally abusive, threw away the prescription, and ordered them out of the office. The Hearing Committee inquired of the witness whether the Respondent had exhibited any prior animosity toward him or his mother. The witness stated that the Respondent was "short" and "sometimes distracted, like someone who was drunk".

In his testimony, the Respondent offered that it was the son who was abrupt and abusive. He also testified that the patient and her son were disrupting to the office staff at their visits, kissing each other and engaging in other inappropriate behavior.

In support of its case against the Respondent, the State presented testimony from a physician who is board certified in internal medicine. He testified that he had reviewed all of the available records concerning the married couple and the patient who was deceased. He testified with respect to the husband patient, that over an eighteen (18) month period, Respondent had given the patient +/-95 prescriptions for narcotics/opiates. There was no notation of an office visit or other patient contact for fifty-two (52) of the prescriptions. The expert found that to be "disturbing". Further, the patient record is devoid of a social history, physical assessment and/or diagnosis that would support the prescriptions for these "powerful drugs".

The expert stated that the Respondent should not have supported the patient's continued drug use, but rather, he should have referred him to a pain clinic. The witness testified that there was an issue of "polypharmacy". Many of the drugs that Respondent

prescribed for the patient overlapped. From January 30, 2001 to February 1, 2001 the Respondent prescribed vicodin ES, oxycontin, tylox, dilaudid and Robitussin EC – all of which are narcotics. Robitussin with codeine was prescribed for this patient six (6) times, yet the patient record contains a notation that the patient was allergic to codeine. That was potentially a life-threatening situation. The collection of drugs prescribed, if taken by the patient, could kill him. The expert testified that Respondent's treatment of this patient fell below the minimum standards of acceptable medical practice.

The expert's testimony was similar with respect to the patient's wife. She complained of neck and shoulder pain for which Respondent provided fifty-three (53) prescriptions for controlled substances. He also wrote twenty-three (23) prescriptions for valium without any notes as to the justification for same. From May 18, 2000 to June 2, 2000 the Respondent wrote prescriptions for three (3) different narcotics, all of which overlap and should not be taken together. Likewise, he prescribed valium and xanax at the same time. They should not be taken together.

The patient's record does not contain any indication of a complete physical examination, diagnosis or plan of care to address the patient's complaints of pain. There is also no evidence that the Respondent was monitoring the patient's vital signs, specifically her respiratory rate while she was taking these drugs. The witness determined that the Respondent's care of this patient also fell below minimum standards of acceptable medical care.

Regarding the third patient, the expert witness testified that the Respondent's documentation is "poor" and "clearly" does not meet the standard of care. The Respondent's notes indicate a variety of other drugs being taken by the patient. The

Respondent did not address those drugs, other than to list them. There is no evidence of an assessment of the patient's problems, an examination or a plan of attack. The Respondent prescribed drugs for that in addition to those she was acquiring from other sources. The Respondent's records indicate prescriptions for codeine products despite the fact that an allergy to codeine is documented.

In rebuttal to the expert's testimony, the Respondent testified that his lack of charting served to confirm that the patients did not sustain any adverse reactions to the prescribed drugs. However, the expert was specific in his testimony that the various different drugs prescribed were virtually served the same purpose and should never have been prescribed together.

The Respondent testified at length. He provided a synopsis of his marital problems that is not particularly relevant to this proceeding, other than as it might relate to the stress under which the Respondent was working. He attempted to persuade the Hearing Panel that his lack of records was not indicative of a lack in medical care. The Respondent admitted that while he was under an Interim Order of referral to the Physicians Health Committee and an agreement to refrain from the use of alcohol and drugs (State's 8), he tested positive for marijuana. He further admitted that, while undergoing treatment at Meadows Edge, he diluted urine screens to avoid being caught using drugs and alcohol.

From the date of entry of the Interim Order in April of 2000 through April 2001, there were several reports of diluted urine samples resulting in failure of adequate screens, and in March, 2001, the Respondent tested positive for marijuana. (State's 19)

Those events taken together with complaints regarding the Respondent's disruptive behavior and patient care, including a complaint from CVS Pharmacy regarding the Respondent's prescribing practices, and the Restraining Order obtained by Dr. Baute, caused the Board of Medical Licensure and Discipline to launch an investigation. Based upon the foregoing, the Director of Health issued a Summary Suspension of the Respondent's license to practice medicine on April 27, 2001. The Summary Suspension also noted the fact that at all times pertinent to these events, the Respondent did not possess a Rhode Island controlled substances registration (CS Reg.). The Respondent admitted that fact. However, at the hearing, it was determined that the Respondent did possess a valid DEA Registration. The Respondent testified that his failure to have a current CS Reg. was due to his oversight when submitting his medical license renewal application.

After his suspension, the Respondent enrolled in a three (3) month rehabilitation program at the Farley Institute in Virginia. He stayed there two (2) months, then moved to a halfway house due to financial constraints. The Hearing Committee was not provided with any records from the Farley Institute.

The Respondent admitted to alcohol and marijuana use, but denied that he ever treated patients while under the influence of either. He vehemently denied having marijuana in his medical bag.

In his testimony, the Respondent stated that his problems and addictions developed as a result of anxiety and stress associated with the dissolution of his marriage and the actions of Dr. Baute and Kent County Hospital. The Respondent testified, and the record supports the fact, that following his ouster from Kent, the Respondent

attempted to gain staff privileges at two (2) other hospitals, but he could not obtain a favorable recommendation from Dr. Baute or the Executive Committee at Kent. The fact that he had no hospital privileges contributed to his stress as he could not properly treat his patients. He testified that he did not appreciate the severity of his problems until he sought help at the Farley Institute. He stated that he is now drug and alcohol free. He testified that he attends AA meetings every day and is undergoing counseling.

CONCLUSIONS AND ORDER

Prior to closing the record on this matter, the State dismissed Counts Seven, Eight, Nine and Twelve as against Dr. Guilfoyle. Therefore, those issues are not considered herein.

COUNT ONE

The panel notes that there is a conflict between the Respondent's testimony and that of Dr. Baute. The panel accepts the fact that the Kent Hospital Executive Committee suspended Respondent's staff privileges and extended to him an offer for reduced privileges under certain conditions. The Respondent determined not to take them up on that offer. The only testimony or evidence relating to the Respondent's case management at the hospital is with respect to the "STAT peg" case wherein the Respondent demanded that patient surgery be conducted over the weekend. It is clear that the hospital had a policy prohibiting non-emergency surgery on the weekend, and that the Respondent violated that policy. That fact, however, does not support a finding of unprofessional conduct. Despite investigation and monitoring of the Respondent's patient care at the hospital for a three (3) month period, no patient care issues were identified.

COUNT TWO

Pursuant to the evidence submitted (State's 19) and Respondent's own admissions, it is clear that the Respondent violated the terms of the Interim Agreement by indulging in the use of alcohol and marijuana. Further, he attempted to conceal his activities by providing adulterated urine specimens. The Hearing Committee finds that Respondent's actions with respect to Count Two constitute unprofessional conduct.

COUNT THREE

Respondent is alleged to have been guilty of unprofessional conduct in that he made statements that he wanted to "whack" a hospital administrator and plant drugs on his wife. The tapes of the Respondent's discussions with his alleged co-conspirator were not presented into evidence. The Panel has determined not to accept as evidence the deposition taken of the Respondent's alleged co-conspirator. That individual was found guilty of criminal conduct directly related to his veracity. There was argument to the effect that the individual gave this testimony in an attempt to gain favor for himself with the FBI. No charges were ever brought against the Respondent. The hospital administrator did obtain a permanent Restraining Order against the Respondent, but it was without objection by the Respondent. Accordingly, the Hearing Committee concludes that there is not sufficient evidence upon which to base a finding of unprofessional conduct with respect to this Count.

COUNT FOUR

It is true that the Respondent wrote prescriptions for controlled substances without a valid CS Registration issued by the State. However, the Respondent did possess a valid DEA Registration, and his CS Registration had not been revoked by the

State. It merely was not renewed. The Panel accepts as credible the Respondent's testimony that he overlooked the CS Registration form and fee when applying for his license renewal. The Respondent is not guilty of unprofessional conduct with respect to Count Four.

COUNT FIVE

The Hearing Committee finds that the Respondent is guilty of unprofessional conduct with respect to his patient care. The record provides ample evidence that the Respondent treated patients while he was under the influence of alcohol, that he falsified medical records, that he made mistakes prescribing for patients, and that he failed to document patient prescription orders. Such activities on the part of the Respondent constitute incompetent, negligent and/or willful misconduct in the practice of medicine.

COUNT SIX

The record is replete with evidence that the Respondent wrote a large number of prescriptions for narcotics for a husband and wife during a fourteen (14) month period beginning in or about January, 2000. The prescriptions were largely written without any medical indications being noted in the patient records. The prescriptions constitute a practice of "polypharmacy". The prescribed drugs overlap and exceed reasonable volumes. There is evidence that multiple pharmacies were used to fill the prescriptions, thus giving rise to an issue as to actual intent of the prescriptions. Further, there is evidence to support a finding that the Respondent changed the medical records of these

patients in order to justify the prescriptions. The Respondent's actions with respect to this Count constitute unprofessional conduct.

COUNT TEN

There is evidence to support a finding of unprofessional conduct with respect to Respondent's treatment of a fifty-six year old patient who subsequently died. The Hearing Committee finds that there was no adequate record relating to the history, assessment or examination of his patient. The record also contains evidence that the Respondent prescribed buspar for this patient despite the fact that he knew, or should have known, that she was addicted to it. Further, he prescribed codeine derivatives and the medical history indicates an allergy to codeine.

COUNT ELEVEN

There is evidence in the record to support a finding that there was a "parting of the ways" of the Respondent with an elderly patient and her son. However, there is insufficient credible evidence upon which to find unprofessional conduct with respect to this Count. Having identified a torn miniscus, the Respondent was not in error in refusing to provide the patient with a prescription for pain while she sought the services of another doctor.

ORDER

Based upon the foregoing, the Hearing Committee hereby **ORDERS:**

1. That the Respondent's medical license is hereby suspended forthwith for a minimum period of eighteen (18) months; and

2. That upon expiration of eighteen (18) months, the Respondent may apply for relicensure. At such time as he applies for relicensure, the Respondent must provide evidence satisfactory to the Board that he

a) has or is engaged in psychiatric rehabilitation treatment to address his practice deficiencies as well as his failure to accept responsibilities;

b) that he is alcohol and drug-free as evidenced by participation in random screenings;

c) that he has undergone retraining in the areas of patient case management and patient record keeping; and

3. If the Respondent is readmitted to the practice, he shall serve a license probationary period for such time and upon such conditions as the Board then deems appropriate.

Entered this 31st day of December, 2002.

YOU HAVE THIRTY (30) DAYS TO APPEAL THIS DECISION TO THE SUPERIOR COURT.

Hearing Committee Chair
Henry Litchman, MD, Physician Member
Albert S. Most, MD, Physician Member
Andrea Maenardi, Public Member

Affirmed as to content and form:

Patricia A. Nolan MD MPH
Patricia A. Nolan, MD MPH
Director of Health

CERTIFICATION

I hereby certify that I have mailed a copy of the within Administrative Decision to the Law Office of Joel D. Landry, Esquire, 194 Waterman Street, Providence, RI 02906 on this 31st of December, 2002.

Carole Ellsworth